Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: DR AHMED KHALIFA 1415 S HWY 6, SUITE 400D SUGARLAND, TX 77478	MFDR Tracking #: M4-09-B472-01
Respondent Name and Box #: INSURANCE CO OF THE STATE OF PA. Rep Box # 19	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "Fee guideline."

Principal Documentation:

1. DWC 60 package
2. Total amount sought - $40.12
3. CMS 1500
4. EOB's
5. Medical Report

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: The insurance carrier did not submit a response to the request for medical fee dispute resolution.

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
4/22/09	01991(X2)	W1	1-6	$0.00
Total /Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.203, titled ***Medical Fee Guideline for Professional Services*** effective for professional medical services provided on or after March 1, 2008, set out the reimbursement guidelines.

1. These services were denied or reduced payment by the Respondent with reason code:
   - W1-Workers Compensation State Fee Schedule Adjustment.

2. On the disputed date of service, the requestor billed the insurance carrier $308.52 for CPT code 01991 (X2) – "Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); other than the prone position." The insurance carrier paid $268.40. The requestor is seeking additional reimbursement of $40.12.
3. Division rule at 28 TAC §133.307(c)(2)(C), effective May 25, 2008, requires the requestor to submit "the form DWC-60 table listing the specific disputed health care and charges in the form and manner prescribed by the Division." A review of the submitted DWC-60 table listed the CPT code 09111X2 as the service in dispute. However, a review of the submitted bills and EOBs identifies the service as CPT code 01991. Therefore, the requestor has failed to complete the required sections of the request in the form and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(c)(2)(C).
4. Division rule at 28 TAC §133.307(c)(2)(E), requires the requestor to submit "a copy of all applicable medical records specific to the dates of service in dispute." A review of the submitted documentation does not contain a copy of the anesthesia report to support the billed services. Therefore, the requestor has failed to complete the required sections of the request in the form and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(c)(2)(E).
5. Division rule at 28 TAC §133.307(e)(1), effective May 25, 2008, states "Request for Additional Information. The Division may request additional information from either party to review the medical fee issues in dispute. The additional information must be received by the Division no later than 14 days after receipt of this request. If the Division does not receive the requested additional information within 14 days after receipt of the request, then the Division may base its decision on the information available. The party providing the additional information shall forward a copy of the additional information to all other parties at the time it is submitted to the Division." On November 9, 2009, the Division notified the requestor that the request for medical fee dispute resolution was missing the anesthesia report and that it was necessary to support the billed service and to determine the maximum allowable reimbursement. To date, the requestor has not submitted the anesthesia report; therefore, this decision will be made based upon the information available.
6. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. 134.203, 133.307
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $16.70 plus applicable accrued interest per Division Rule 134.130 due within 30 days of receipt of this Order.

ORDER:

		11/20/09
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.